Referral for Telemedicine Consultation

Primary Care Provider Information		
Last Name	First Name	Please attach physician label here (Including OHIP billing #)
Phone Number	Fax Number	

Patient Information		
Last Name	First Name	Please attach patient label here (Including OHIP #)
Patient Best Contact #	SDM Name and Contact #	

Consultation Request	
Preferred Specialist Name	☐ Urgent – please call 416 586 4800 ext. 2844 ☐ Non – urgent ☐ Initial ☐ Follow-up ☐ Interpreter services required - if so please specify: If other, Please specify:
Specialty Requested	☐ Please recommend a specialist in the discipline indicated

☐ **Copy of Continuous Patient Profile attached** (medical summary, medication list, recent labs, investigations, old consult notes)

Reason for Consultation Request

Signature: _____ Date: _____

Please fax referral form and all supporting documentation to (416) 586- 3168